RIDGEVIEW

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Internal Use Only: Completed By Initials: _____ Date: _____

PATIENT INFORMATION	Patient Name			Date of Birth
	Street Address		Email Address	
	City	State	Zip Code	Phone Number
RELEASE MY MEDICAL RECORDS FROM **check one option**	☐ Ridgeview (optional: specify location or provider below)	**– OR –**	☐ Hospital/Clinic/Provider (required: specify name below)	
	Street Address			Phone Number
	City	State	Zip Code	Fax Number
SEND MY MEDICAL RECORDS TO **address field is required**	Person/Business/Hospital/Clinic	Phone Number		Fax Number
	Street Address	City	State	Zip Code

PURPOSE FOR RELEASE

☐ Continuing Care ☐ Personal Use/Review * ☐ Litigation/Legal * ☐ Insurance Application * ☐ Insurance Payment/Claim
☐ Social Security Disability * ☐ Social Security Appeal ☐ Disability Insurance ☐ Other * _____

**Fees may be charged in accordance with MN Statute §144.2923 and Federal Rule 45 C.F.R. §164.524*

INFORMATION TO BE RELEASED:

What information do you want dislosed?

I want my records related to: _____

I want my records for dates of service: _____

☐ Home Care and Hospice ☐ Pathology Slides/Blocks* ☐ Radiology Images* *(*Will be sent separately)*
☐ Clinic Record Set (office visit notes, lab, radiology report, med list, immunizations)
☐ Hospital Record Set (history & physical, discharge summary, operative report, consultations, emergency records, lab, radiology report)

Individual Report Options:

☐ Discharge Summary/Note	☐ Clinic/Progress Notes	☐ Laboratory Reports	☐ Immunization Record
☐ History & Physical Exam	☐ Emergency/Urgent Care	☐ Pathology Reports	☐ Allergy Record
☐ Operative Report	☐ Rehab Notes (PT/OT/ST/RT)	☐ Radiology Reports	☐ Medication Record
☐ Consultations	☐ Home Health/Hospice	☐ EKG/ECHO	☐ Itemized Statement

☐ Any and All Records (includes ALL types of records at Ridgeview ☐ Other Records (specify type): _____

Special Disclosure Declinations

(Please note: if you do not mark any boxes, these items may be released with this request)
☐ Chemical Dependency/Substance Use Program Records ☐ Genetic Counseling Records ☐ Mental Health Records ☐ HIV Test Results

RELEASE METHOD/FORMAT

➡ **Date Records are Needed (appointment date): _____ / _____ / _____ (NOTE: PLEASE ALLOW 10-15 DAYS FOR PROCESSING)**

☐ Ridgeview MyChart	☐ U.S. Mail (Paper)	☐ U.S. Mail (CD/DVD)
☐ Fax (Patient Care Only-See Above)	☐ Pick Up at Ridgeview location (by appt only)	☐ View Record
☐ Verbal (no records will be sent)	☐ Secure Email: _____	

Person to allow verbal release to: _____

**NOTE: I acknowledge that by electing to receive my health information via a non-secure manner that the information will not be encrypted, and that it could be intercepted and viewed by a third party. Ridgeview is not responsible for unauthorized access of your health information while in transmission to the location you designated above.*

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____ /_____ / _____
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Ridgeview Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- Ridgeview will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Ridgeview records may include records that it received from other organizations. If these records have been used by Ridgeview and filed in the record Ridgeview maintains about you, these records may be released with your Ridgeview records.
- Ridgeview cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Ridgeview from any and all liability resulting from a redisclosure by the recipient.
- Federal Rule 42 CFR part 2 prohibits unauthorized disclosure of Substance Use Program Records.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

Patient/Legal Guardian Signature	Date	Authority to act on behalf of patient (attach document)

Directions for Completion of Form

Patient Information: Complete the entire section which identifies clearly and legibly all of the demographic information specific to the patient (individual about whom information is being requested).

Release My Medical Records From: Check the first box if you would like your records released from a Ridgeview facility/provider. Check the second box if you are requesting your records be released from a non-Ridgeview Health facility/provider. When checking the Ridgeview option, please specify the specific Ridgeview location you are seeking information from. **Please be specific** in your request. For example, Two Twelve Medical Center, Chaska, MN; Ridgeview Waconia Campus Hospital, Waconia, MN; Ridgeview Delano Clinic, Delano, MN. If you do not identify a specific hospital or clinic (e.g. Ridgeview), records may be provided from ***ALL*** Ridgeview hospitals or clinics where you have received care. Please see ridgeviewmedical.org/location/ for a listing of Ridgeview hospital and clinic locations and addresses.

Send My Medical Records To: Identify the full name/business, address, phone and contact information with the name of the individual who is to receive the information. *Please allow 10-15 days for all requests to be processed and sent to the recipient.*

Purpose For Release: Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

Information to Be Released: This section gives us the instructions for what information you want released. If you select “Clinic Record Set” or “Hospital Record Set”, we will disclose the pertinent documents that are specific to that type of patient care visit. This is typically what doctors’ offices, hospitals or other health care providers need to provide information related to your care. If you select “any and all” records, your entire record will be provided for a specific visit date or all dates. It is very helpful if you identify the date or range of dates, needed by the requestor. Please note record types listed in the Special Disclosure Permissions section must be checked in order for them to be released.

Release Method: This tells us how you would like your information delivered. If you wish to view information prior to selection of documents, please identify this on the authorization form and we will contact you to set up a viewing appointment. Please note that viewing appointments are done at the Ridgeview Waconia Campus in Waconia. If you wish information about you to be shared verbally or for an authorization to be on file for others to have access to your medical information, please write this in this section (example: form on file for access by my husband upon his specific request). Please note: there are size limitations when emailing records.

Duration of the authorization, revocation and other information you need to know: This authorization will automatically expire in 12 months **unless** you include a different date. You may indicate the authorization is valid “5 years”, “10 years”, but there needs to be an ending date (do **not** use terms such as “lifetime” or “forever”). The authorization can be revoked by your written direction to our organization.

Contact Information for Patient Record Copies

Ridgeview
Attn: Health Information Management/ROI
500 S. Maple Street
Waconia, MN 55387
Phone: 952.777.4168
Fax: 952.442.6037
Email: medicalrecords@ridgeviewmedical.org

For a list of Ridgeview locations and addresses, please visit RidgeviewMedical.org